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Comments and Responses Regarding Draft Local Coverage Determination: Ophthalmic A & B Scans

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As an important part of Medicare Local Coverage Determination (LCD) development, National Government Services solicits comments from the provider community and from members of the public who may be affected by or interested in our LCDs. The purpose of the advice and comment process is to gain the expertise and experience of those commenting.

We would like to thank those who suggested changes to the draft Ophthalmic A & B Scans LCD. The official notice period for the final LCD begins on April 15, 2009, and the final determination will become effective on July 1, 2009.

Comment:
The Connecticut Optometry representative suggested adding ICD-9 code 365.02 (anatomical narrow angle)

Response:
We will add the suggested diagnosis code. However, ophthalmic ultrasound should only be performed for this indication when gonioscopy is inconclusive or not reliable.

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Comment:
The New York Ophthalmology CAC representative offered the following comments:
The Draft Policy (DL28174) Ophthalmic A and B Scans excludes the conditions for which an A Scan is performed pre-operatively to cataract surgery and used for IOL calculation. That said, the draft policy under current review places together the two scans and combines the medically necessary codes into a single policy. The problem with doing so is that most of the ICD-9 codes belong only to B Scan application. For the most part, the diagnostic A Scan has limited use. It is best suited to look at the internal reflectivity of certain conditions, the most common of which is a choroidal melanoma. It is conceivable that a disciform scar, clinically, would be confused with a choroidal melanoma, and in that setting, the A Scan would be of help to differentiate between the two conditions. Simultaneous A and B Scans are helpful with vitreous hemorrhages and retinal detachments. If both A and B Scans are kept

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as one policy, it may be best to separate out those ICD-9 codes specific to A from B Scans. Several ICD-9 codes are of questionable support with respect to either A or B Scans (366.11, 379.91). If clinically there were an unobstructed view of the posterior pole and peripheral retina, it would be hard to justify performance of the scan supported by codes such as 366.52, 368.03, 371.01, 371.02, or 379.93.

Follow-up Emails from the New York Ophthalmology CAC representative:

After several calls made to Retina colleagues, the general concensus is that almost no one performs an isolated A- Scan. Thus the frequency of CPT 76511 ought to be very low. In general, the A- Scan provides information about "internal reflectivity." This proves to be beneficial in only diagnosing melanoma. Nevertheless, the retina teams would use the combined scans for sequential monitoring.

I was able to connect with a leader in the Retina community who actively lectures and Chairs AAO and ASRS meetings. His practice is in Maryland and he is a voluntary faculty member at Hopkins. We both should feel confident in his opinion, which follows. I trust you will find this useful.

- For ICD codes 190.0 through 242.91 - All CPT codes (76510, 76511, 76512 and 76513) except 76529
- For ICD codes 360.00 through 360.21 - All CPT codes except 76511 and 76529
- For ICD codes 360.51 through 360.64 - All CPT codes except 76511
- For ICD codes 361.00 though 362.43 - All CPT codes except 76529
- For ICD codes 363.40, 363.41, 363.42, 363.43 and 363.50, I don't think these should be covered for any of the ultrasound codes
- For ICD codes 363.70 through 363.8, All CPT codes except 76529
- I don't have an opinion about ICD codes 366.00 through 376.9
- For ICD codes 377.21 through 379.42. All CPT codes except 76529
- I don't have an opinion about 379.8 though 743.39
- For ICD codes 743.51 through 871.6. All ultrasound CPT codes OK

Response:
We appreciate the extraordinary effort of the Ophthalmology CAC representative in reviewing this LCD and in obtaining additional counsel from others in the specialty. We will revise this LCD so as to identify the specific diagnosis codes for each service, as suggested.

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Comment:

The Ophthalmology representative to the Indiana CAC stated, "This policy appears to be complete and has an excellent description of the abstract and indications for ophthalmic ultrasound. The list of ICD-9 Codes is broad and appropriate. My only concern is with the utilization guideline. The accepted frequency of three services per eye in a 12-month period is not unreasonable for the vast majority of ocular diagnosis; however, situations such as ocular trauma, endophthalmitis with dense vitreous opacities, and nonclearing vitreous hemorrhage, especially in association with possible retinal detachment, and choroidal malignant melanoma treated with brachytherapy are situations were repeat ultrasound is required often more than three times within a one year-period. I would suggest that the utilization guidelines be at least consistent with other tests such as angiography and provide at least a minimum of four services per eye within a 12-month period to cover the possibility of situations such as trauma or choroidal melanoma brachytherapy treatment and follow-up. This provision will allow better patient care in those conditions that will require more frequent ophthalmic ultrasound."

Response:

We appreciate the commenter's review of this LCD and supportive comments. We have previously discussed the frequency of ophthalmic ultrasound with a New York ophthalmologist with expertise in the treatment of ophthalmic tumors, and agree that the frequency of scans should be increased to four times per year per eye for evaluation and treatment of intraocular tumors. We believe that that frequency in other non-acute conditions is more limited, but agree that we must allow for the acute conditions noted by the commenter. We will revise the LCD accordingly to increase the frequency to four times per year per eye.

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